# MONTANA MEDICAID/MHSP/CHIP
# INDIVIDUAL ADJUSTMENT REQUEST

**INSTRUCTIONS:**

**This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).**

## A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS

Name

Street or P.O. Box

City State Zip

2. CLIENT NAME

3. INTERNAL CONTROL NUMBER (ICN)

4. PROVIDER NUMBER

5. CLIENT ID NUMBER

6. DATE OF PAYMENT

7. AMOUNT OF PAYMENT $

## B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

| | DATE OF SERVICE OR LINE NUMBER | INFORMATION STATEMENT | CORRECTED INFORMATION |
|---|---|---|---|
| 1. Units of Service | | | |
| 2 Procedure Code/N.D.C./Revenue Code | | | |
| 3. Dates of Service (D.O.S.) | | | |
| 4. Billed Amount | | | |
| 5. Personal Resource (Nursing Home) | | | |
| 6. Insurance Credit Amount | | | |
| 7. Net (Billed - TPL or Medicare Paid) | | | |
| 8. Other/REMARKS (BE SPECIFIC) | | | |

**SIGNATURE:** _____ **DATE:** _____

**When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).**

**MAIL TO: ACS**
**P.O. Box 8000**
**Helena, MT 59604**